COUNTY MEDICAL SERVICES PROGRAM (CMSP)
RECORD OF HEALTH CARE COSTS—SPENDDOWN

Read instructions on the back of this form before completing.

Case name — First, Middle, Last

Address

City, State, ZIP Code

Medical expenses of family members listed below may be used to meet the spenddown.

Medical expenses incurred in the month of application may be listed below when you have paid for them.

Month: _________ Year: ___________

Co.	Dist.	COUNTY USE			

SPENDDOWN
The amount family members must pay for medical expenses:
$___________________________

Family members ❐ will ❐ will not be required to pay or obligate an additional amount toward medical expenses (Form CMSP 177 S) for the month(s) listed above.

State Number					Name—Last, First, Middle	Date of Birth Month Day Year	Sex	Other Coverage Code	(1) Social Security Number / (2) HIC or RR Number
Co.	Aid	7-Digit Serial Number	FBU	PERS					
									(1) (2)
									(1) (2)
									(1) (2)
									(1) (2)
									(1) (2)
									(1) (2)
									(1) (2)

Declaration of provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider hereby declare that I received payment from the patient for the amount shown in the "Paid by Patient" column and that I will neither claim nor accept payment from the CMSP for that amount. I also understand and agree that I may seek payment from the CMSP for the costs of CMSP covered services in excess of the amount paid by the patient if the patient becomes eligible for CMSP and meets any additional share-of-cost.

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the service to be paid or the charge.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or the California State Franchise Tax Board.

		Date of Service Month	Day	Year		Proc. Code/ Presc. No.	Total Bill	Paid by Patient
Provider Name	Provider Number				Service		$	$
Patient Name								
Provider Signature (See declaration above.)								
Provider Name	Provider Number				Service		$	$
Patient Name								
Provider Signature (See declaration above.)								
Provider Name	Provider Number				Service		$	$
Patient Name								
Provider Signature (See declaration above.)								
Provider Name	Provider Number				Service		$	$
Patient Name								
Provider Signature (See declaration above.)								
Provider Name	Provider Number				Service		$	$
Patient Name								
Provider Signature (See declaration above.)								

STATE USE ONLY

Date of Certification			Reviewed by:
Month	Day	Year	

I have read the instructions on the back of this form. I have paid the amounts listed above in the "Paid by Patient" column.

Signature of Applicant

Date

See Reverse

Instructions to Patient:

On the other side of this form, the amount you must pay before you are eligible for CMSP is shown in the space labeled "Spenddown." Take this form with you to any doctor, pharmacist, hospital, or any other provider of medical care in the month(s) specified. Be sure to tell the medical provider that you have a CMSP number and give him this form. He will fill in the amount of his total bill and the amount you must pay; the amount you must pay should not be more than the amount listed in the "Spenddown" space. *When you have paid this amount, do not pay any more.* After you have reached the amount you must pay, sign your name and enter the date at the bottom of the form. Keep the last copy for your records. Send the original and the other two copies to your county department. If this form is approved, you are determined eligible, and any other forms your worker asks you to complete are approved, you will receive a CMSP card. As soon as you get your CMSP card, take it to the providers of medical services who have signed the front of this form so they can bill CMSP for the services for which they have not been paid. If you have any problems in using this form, call your eligibility worker.

The types of services which can be listed on this form are:

Physician
Dental
Prescribed Drugs
Laboratory
X-Rays
Chiropractic
Clinical Psychology [only institutional as in hospital care (inpatient or outpatient), other organized outpatient care, and Short-Doyle clinic]
Assistive Devices (e.g., crutches, wheelchairs, walkers, etc.)
Blood
Optometrists
Christian Science Facilities
Christian Science Practitioner
Hospital Care (Inpatient or Outpatient)
Nursing Home Care
Other Organized Outpatient Care
Prosthetic or Orthotic Appliances
Physical or Occupational Therapy
Speech Therapy
Essential Medical Transportation
Podiatry
Optician
Short-Doyle Clinic
Audiologists
Hearing Aids
Home Health Agencies

Instructions to Providers:

This form is to be used to establish eligibility for CMSP payment for the persons listed on this form. The following verification is required: That the patient has paid the amount listed in the space labeled "Spenddown," and that the patient has obtained the provider's declaration that payment was received. The provider's signature meets this requirement.

In completing the form, please observe the following:

1. Be sure the services listed were provided in the month listed at the top of the form.

2. Fill in you name, provider license number, and the exact dates of service. Do *not* list dates such as "April 2 through April 10," but list each separate month, day, and year in which services were provided.

3. In the space marked "Total Bill," enter the total charge for service. Do *not* enter in this space any amount billed to Medicare.

4. In the "Paid by Patient" space, list only the amount the patient is to pay. This amount is *not* to exceed the amount entered at the top of the form in the "Spenddown" space. If other providers have made entries on the form, make sure their charges to the patient, plus your charges, do *not* exceed the amount in the "Spenddown" space.